

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

MEDICAL EXAMINING BOARD

APPLICATION FOR CERTIFICATION TO PRACTICE RESPIRATORY CARE

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

☐ Your name and address are available to the public.

PLEASE TYPE OR PRINT IN INK

☐ Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.)

Last Name	First Name	MI	Former / Maiden Name(s)
-----------	------------	----	-------------------------

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth ____ month ____ day ____ year	Daytime Telephone Number (____) _____ - _____
--	--

Ethnic/gender status information is optional. Sex: ☐ M ☐ F Ethnic: ☐ White, not of Hispanic origin ☐ American Indian or Alaskan
☐ Black, not of Hispanic origin ☐ Asian or Pacific Islander
☐ Hispanic ☐ Other

Have you ever held a license/credential in the state of Wisconsin? ____ Yes ____ No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

The respiratory care certification expires on 10/31 of the (even or odd)-numbered year. It may be renewed for a two year period at that time.

School Name: _____

School Address: _____
(City) (State)

Date Diploma Granted: _____
month/day/year

Degree: _____

Specialty: _____

BOARD OFFICE USE ONLY

Temporary Permit Requested: ____ Yes ____ No

APPLICATION FEES Please check applicable blank: (Make check payable to Department of Regulation and Licensing and attach to application).

____ \$ 53.00 Initial Credential Fee
____ \$ 57.00 State Law Exam
\$ 110.00 Total fee attached*

____ **TEMPORARY CERTIFICATE ISSUED PRIOR TO A PERMANENT CERTIFICATE** (Only applicable for those candidates scheduled to take the NBRC exam or awaiting results.)

\$ 10.00 Is required in addition to the above fee (*non-refundable*)

***ORAL EXAMINATION FEE: \$266.00** If you should be selected for an oral examination, the additional oral examination fee will be required prior to being scheduled for the exam.

For Receipting Use Only

Wisconsin Department of Regulation & Licensing

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Fee(s) attached to this application.

Letters from all State Boards where licensed
(includes active and inactive licenses).

Certificate of Professional Education
(Form #1792).

Wisconsin Statutes and Rules Examination
Booklet and Answer Sheet.

Copies of malpractice suit(s).

Verification of certification from the National
Board for Respiratory Care (Form #1793).

IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.

PRACTICE: Account for all activities and practice from date of graduation to the present time. **Must include professional and nonprofessional activities. ALL time and dates must be accounted for.**

	<u>LOCATION</u>	<u>DATES (from - to)</u>	<u># OF HOURS</u>	<u>JOB TITLE &</u>
	Employer Name/City, State/Country	mo/yr	<u>PER WEEK</u>	<u>DUTIES</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

I AM CREDENTIALIAED IN THE FOLLOWING STATES (UNLIMITED):

By Written Exam: _____

By Endorsement/Reciprocity: _____

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN CREDENTIALIAED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN MEDICAL EXAMINING BOARD. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, CREDENTIAL NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR CERTIFICATION.

PLEASE CHECK ONE FOR TEMPORARY CERTIFICATE:

_____ I plan to take the next National Certifying Examination on _____
month/day/year

_____ I have taken and passed the National Certifying Examination.

Wisconsin Department of Regulation & Licensing

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary)

	<u>YES</u>	<u>NO</u>
1. Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever failed to pass any state board examination, national board examination, or NBRC examination? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/>	<input type="checkbox"/>
5. Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	<input type="checkbox"/>	<input type="checkbox"/>
9. Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	<input type="checkbox"/>	<input type="checkbox"/>

Wisconsin Department of Regulation & Licensing

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice respiratory care" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned respiratory care judgments and to learn and keep abreast of respiratory care developments; and
2. The ability to communicate those judgments and respiratory care information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform respiratory care tasks such as examination and treatment procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years**.

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 12. Do you have a medical condition which in any way impairs or limits your ability to practice respiratory care with reasonable skill and safety? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does your use of chemical substance(s) in any way impair or limit your ability to practice respiratory care with reasonable skill and safety? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you currently engaged in the illegal use of controlled dangerous substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |

Wisconsin Department of Regulation & Licensing

AFFIDAVIT OF APPLICANT (Sign and date in the presence of a notary)

I state that I am the person referred to on this application and that all the answers set forth are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Medical Examining Board or the Wisconsin Department of Regulation and Licensing will be cause for disciplinary action.

Signature of Applicant

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20____, by _____
(Applicant name)

Signature of Notary Public

S E A L

Date Commission Expires

Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.¹ A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

First Name Middle Initial Last Name

Profession

Date of Birth _____ _____ _____
 month day year

- -

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,² to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,³ and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.⁴

¹ Section 440.03 (11m), Wis. Stats.

² Sections 49.22, and 440.13, Wis. Stats.

³ Section 440.12, Wis. Stats.

⁴ Health Insurance Portability and Accountability Act (HIPAA) of 1996